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ABSTRACT

The elderly have recently become a target of national concern. There are currently more than 22 million people 65 years of age or older in the United States, and this number is continually increasing. Health education must respond to the need for better understanding of the aging process and the aged by including information and materials designed toward developing competencies in aging in professional preparation programs. Higher education professionals should develop expertise in the area of aging and make this competency available to other programs in academic and community settings. Students of health education in higher education should be provided opportunities for field experiences in various agencies involved with the aged. Elementary and secondary schools must include information and materials concerning aging in the health education curriculum. Community schools and community colleges should provide special education opportunities for the aged, and health educators should become involved in training professionals, paraprofessionals, and volunteers working with the aged. (Author/PB)

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Aging: Health Education's Responsibility

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Aging. Health Education's Responsibility

Bill C. Wallace

The elderly have always been a part of society, but it has only been in recent years that they have been the target of national concern. Since the founding of the Club for Research on Aging in 1940 through the establishment of the National Institute on Aging in 1974, a great deal of time and effort has been spent investigating the needs and interests of this segment of the population. Much of this concern is due to drastic changes in the makeup of the population.

Expected Population Changes:

Today we live in an aging society. Demographic experts explain this by saying that a population is aging when the elderly segment is increasing faster than all others. This can be demonstrated by comparing the fact that in 1860 only 13 percent of the population was forty-five years of age or over in contrast with an expected proportion of 40 percent by the year 2000. It can be demonstrated even more vividly by population figures published in the March 3, 1975 issue of U. S. News and World Report.(1) These data are broken down into five categories: Children and Teen-agers; Young Adults, 20-34; Younger Middle-aged, 35-49; Older Middle-aged, 50-64; and People 65 and Over.

It was reported:

1. There are (1975) 74,839,000 children and teen-agers; by the year 2000 there will be 80,743,000 or an 8 percent increase.
2. There are (1975) 50,169,000 young adults, 20-34; by the year 2000 there will be 54,925,000 or a 9 percent

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increase.

3. There are (1975) 34,665,000 younger middle-aged, 35-29; by the year 2000 there will be 60,885,000 or a 76 percent increase.
4. There are (1975) 31,746,000 older middle-aged, 50-64; by the year 2000 there will be 39,065,000 or a 23 percent increase.
5. There are (1975) 22,262,000 people 65 and over; by the year 2000 there will be 28,842,000 or a 30 percent increase.

These data further indicate that four-fifths of all population growth in the next twenty-five years will be among people thirty-five and older. What are the implications here for health education; and how does this predicted change in the profile of our population affect health education?

Health Education's Relationship to Aging:

To answer these questions, let's turn to the topic of health education as it relates to aging. Health education should be considered an affirmative enterprize. For instance, it is based on the assumption that it will lead to a better quality of life. It also proceeds on the collateral assumption that the learner in health education has the ability to control, at least to a major degree, his health status. Thus, because of its faith in the ability of society to respond positively, health education may in contrast to other areas in the field of aging, provide the vehicle for happier, healthier, and more productive lives

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for "Older Americans."

Learning is a way of life today. No one is able to function adequately in terms of coping with physical, social and psychological needs unless he is willing to be a learner all of his life. In order to cope with all of these needs, health education must be considered as being continuous as change itself; and must also be programmed so that all persons, regardless of age, may take part in learning for better health throughout their lives.

There are all kinds of services for the aged: medical, financial, legal, housing, transportation, nutritional and general education. Where is health education? If it is not present, whose fault is it? Has health education responded to the needs of the aged? A better question may be has health education responded to the needs of everyone concerning aging? We must remember that health knowledge of older persons is based on their memory of the schooling received in childhood and youth. This image will no doubt bear little resemblence to their current physical, psychological and social health needs. If we ask them questions concerning their need for health education, their response would often be "Why do I need it? What can it do for me now? My needs are better services, more money to pay for medical care," etc.

An attitude such as this could impose severe limitations on the potential of health education to aid older persons in coping effectively with their survival needs, much less their ability to become more active and live fuller and richer lives. Instead of thinking of health education as a frill or something that comes after all of the older

persons' other needs are taken care of, it should be regarded as a principle component of all the services designed to meet the necessities of living.

Specifically, health education should be a basic element in the production, maintenance and protection of the older persons' health. It should play a major role in solving problems such as the lack of proper diet, adjustments within society that come in later years, selection of proper medical services, community organization and many others. In short, health education should be regarded as an educational component to which all other aspects of living in later years are related. It should be the process which would be used to carry the burden of dissemination of information and knowledge, positive attitude development and behavioral changes concerning aging. This would include all levels and categories of health education within the school and community. Education for aging within health education should be relevant for persons of all ages, not just those in later years.

Situations Involving Health Education and Aging:

In order to clarify this point, let us look at several situations: 1) School age students from kindergarten through senior high receiving instruction in the various areas of the health curriculum, becoming conscious of the relationship of what they are learning at the present to their future as older persons; 2) Students becoming conscious of the fact that they will live longer and that there will be more older people in the United States during their later years than

ever before; 3) Students becoming familiar with the services for and the needs and interests of the present older people.

Another situation is young adults, while learning a trade or engaged in higher education, developing a better understanding of the physical, mental and social aspects of aging. This could be in a formal classroom or activities provided by the community health educator.

A third situation would include adults in the mainstream of productive activity. This segment of the population definitely has a great deal at stake in continuing education concerning later years. By this time, they may have a greater readiness for information concerning their present health and fitness and be better able to relate it to the future. They need instruction concerning the problems and opportunities of living in the period beginning at age sixty-five. There is a two-fold reason for this. First, since they are in their "productive years," they need a better understanding of the problems of aging and the aged to enable them to provide a favorable climate of support and acceptance in which programs may develop. Secondly, even at age forty or forty-five, they need to think constructively about their present health as it relates to the rest of their "productive" and retirement years. In our youth-oriented society this may be a greater task than expected. Frustration may develop in trying to persuade middle-aged persons to think of their health today as it relates to the future; however, the need for this is a strong argument for the relevance of thinking of education for aging within

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the realm of community health, not only for those sixty-five and older, but also those who are not yet "older" but are irreversibly on their way to becoming so.

Let's also picture persons sixty-five and beyond, the group that only 25 percent are high school graduates, those that lived most of their lives in a period when nearly all education was geared to younger persons and their preparation for the "productive" years. These are the people who now make up more than 10 percent of the overall United States population. They not only make up more than 10 percent of the population, but the Senate Committee on Aging(2) has recently reported that the man who is now sixty-five may expect to live to be seventy-eight and the woman who is presently sixty-five probably will make it to her eighty second year. It is evident that these individuals can expect several more years of life, the question arises: What will the quality of this period be? This question may be answered to a degree by attempting to develop a profile of people sixty-five and older.

Most "Older Americans" have the following characteristics: 1) an uncertainty of personal worth due to a loss of status; 2) feelings of inadequateness coupled with marked insecurity; 3) feeling of the lack of ability to meet the demands of life; 4) apprehension about health; 5) difficulty in adjusting from the work-a-day world to one of retirement; 6) lack of personal gratification due to inability to find avenues of service; 7) difficulty in meeting stresses against established practices created by social change; and 8) limited incentive

to combat social disengagement.

For many of these same individuals, illness serves as a major cause of poverty by reducing their incomes; and conversely, lack of money can be a major contributing factor to illness when it serves as a barrier in receiving adequate medical care. This age group spends a greater proportion of their income on medical care than does the rest of the population. This is due largely to the fact that their incomes are less than the national average, but their medical costs are higher. They use more physician services than do young persons. The aged have more admissions to hospitals and stay longer. Older people are the prime users of nursing homes. The Senate Subcommittee on Long Term Care(4) recently reported that there are over one million "Older Americans in nursing homes and that the average charges are six hundred dollars a month as contrasted to average Social Security benefits for a retired couple of three hundred and ten dollars a month.(5) The aged per capita expenditure for prescribed drugs is three times greater than those under sixty-five. Those aged with severe disabilities have even greater expenditures for drugs than those with no disabilities.(6) While composing only slightly more than one tenth of the population, they account for at least 25 percent of medical spending.(7)

Old people experience a good deal more acute and chronic disease than the younger population. As a result of population changes, there is a much greater incidence in cardiovascular and renal diseases, cancer, diabetes mellitus, arthritis, rheumatism, and

the mental and physiologic changes associated with the final years.(8) Since long-term illness, chronic disease and disability comprise the bulk of the health problems of adults in their later years, it is only logical that we have witnessed a turn around in the leading causes of death within the last seventy-five years. Lest it appear that aging is synonomous with disease or chronic illness is inevitable, one must keep in mind that even though the United States Census Bureau reports about 85 percent of the elderly have one or more chronic health problems, less than 5 percent live in institutions and 80 percent or more are able to get around without assistance. As early as 1948, The National Health Assembly stated aging is not a disease and issued the challenge that many people could enjoy health and vigor in their older years.(9) This led to an increased interest in the problem and a few investigators, in an attempt to gain a more realistic picture of aging, began studying healthy old people. The National Institute of Mental Health undertook collaborative studies involving separate academic disciplines and medical specialties over a period of eleven years. These studies and findings of the NIMH were optimistic and in general, reinforced the hypothesis that much of what had been called aging is really disease.(10) Much of this research has led to the idea that diseases of the aged are not, as previously thought, peculiar to the aged. Heart attacks, for instance, are not matters of advancing old age, but of advancing disease. What we are witnessing among the older population suffering increased incidence of chronic diseases and impairments is senescence, those degenerative changes that

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occur after maturity which ultimately culminate in death. We may rejoice with the lengthening of the life-span; but with it, increasing numbers are not only growing old but sick and disabled as well. Health education has a vital role in reducing the number of older people who are not enjoying a full life. This role begins early.

The aged may also be pictured as those who in the last few years have had many new programs developed for them at the local, state and national levels. Many of these programs center around health problems and needs of the elderly. They include pre-retirement counciling, home aid service, nutritional assistance, housing, income, rehabilitation, transportation, research and training, education, Medicare, Medicaid and others. Each of these services in which the "Older Americans" participate hold opportunities for health education.

In summary, health education for aging is more than health education for older people. Health education should be considered for life-long development. Health education for older persons gives health educators a reason for looking at the complete life span as a whole. Technically the process of aging begins at birth and may be considered the sum total of changes that occur in an individual throughout the course of life. Birth may seem a far cry from the problems of survival which beseige the older population; it reminds us that one cannot get from one point in life to the other without passing through all of those in between. Thus, the quality of the past and the future is dependent upon all the experiences in between. In other words, the more positive the health education experiences along this

continuum, the better the chances for the individual to reach his full potential as a healthy, vigorous person. If health education is to make a positive contribution for life-long fulfillment, it must be patterened not only to the needs and interests of youth, but to the stages of life also. These last stages become the guide for all health education experiences leading to old age. Health education must not only be designed to help the aged cope with the requirements of survival but must also help them successfully reach that last stage of life.

White House Conference on Aging:

The needs, interest and circumstances of the aged contributed to many recommendations at the 1971 White House Conference on Aging which have a direct relationship to health education. Those that have significance for health education are too lengthy to report here, but they included such suggestions as the development of educational programs, appropriate materials and methods about all aspects of aging. These programs were to include education to preserve health, and the biological, psychological and social factors associated with aging. It was further recommended that programs be made available to all ages utilizing the public schools and other appropriate agencies. Other suggestions were that higher education provide opportunities for workshops, institutes, inservice education and that teacher training programs include positive concepts regarding the aging process and the older person for incorporation into elementary and secondary schools.(11) Another question becomes apparent: What is health education's

responsibility in response to these recommendations?

Recommendations to Health Education:

Health education is constantly evolving; it is not independent of what is happening in society; it is very much a part of life. In turn, life or the world around us serves as a barometer to health education, supplying us with hints of what the needs of society are concerning its health and wellbeing. There are two types of changes with which health education must deal, knowledge in the area of the health sciences and a restructuring of the population. Since knowledge in the health sciences is well understood and we have moved from a young to an aging population, the latter will be used as a basis for drawing conclusions and making recommendations concerning health education's responsibility in aging.

In light of our changing population and current literature on aging the following recommendations are:

1. Professional preparation programs in school and community health education include information and materials designed toward developing competencies in the area of aging in their curriculum.
2. Health and safety departments in higher education should develop some expertise in the area of aging and make this competency available to other programs in the academic and community setting.
3. Health and Safety departments should become involved in workshops, seminars and other activities concerning aging.

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4. Provide for the student in higher education opportunities for field experience for credit in the various agencies involved with the aged.
5. Health educators at all levels in the academic setting and those in community develop some competency in the area of aging.
6. Health educators become involved in research concerning aging as it relates to the various aspects of health education.
7. The inclusion of information and materials on aging in the health education curriculum of the public schools.
8. Community health education should become involved, working directly with the aged to help them cope with threats to their survival.
9. The health education programs in the community schools and community colleges should provide special educational opportunities for the aged.
10. Health education should become an instrument for helping deliver the various services set up to meet the survival needs of the aged.
11. Health education should play a major role in changing the negative attitudes toward aging and the aged to positive feelings.
12. Health educators should become involved in training professional, para-professional and volunteers working

with the aged.

Now is the time for health education and health educators to become concerned with aging and all of its ramifications. If we are to be charge agents for all of society, we must be just as concerned for the aged as we are for the young. When we adjust our thinking in this direction, we will be assisting the young and the old in becoming a more effective resource for the improvement and enrichment of society.

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